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ABSTRACT

This monograph provides teachers, counselors, administrators, and other school staff members with a simple and practical guide to becoming "response-ready" when dealing with suicide. The first chapter discusses the fact that self-destructive behaviors are prevalent in students which affect their willingness to learn and the increasing incidences of adolescent drinking, motor vehicle accidents, marijuana use, pregnancy, abuse, truancy, and suicide are discussed. The second chapter discusses the role of schools in suicide prevention, including in loco parentis, the Kelson case which held that parents of a child who committed suicide could take action against the school, handling of potential suicide cases, limitations of the school's role, and components of a suicide intervention program. The third chapter discusses the crisis team approach focusing on who should be involved, crisis team responsibilities, and other approaches. The fourth chapter describes a contingency plan of a public high school. The fifth chapter lists 12 mistakes to avoid. The sixth chapter lists 10 ways teachers can help in student suicide prevention. The appendix includes material from other publications on suicide myths, prevention, and intervention. References and a bibliography are included. (ABL)

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Student Suicide

*This book is dedicated to students who have chosen
life and to those who have assisted in making the
choice.*

—J.A.V.

Student Suicide:

A Guide for Intervention

by John A. Vidal

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National Education Association
Washington, D.C.

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PREFACE

Four in 21. This is not a mathematical equation, but rather, a very sad description of loss. During a 21-month time period, four Golden High School students, Jim, Aaron, Leslie, and Tim, completed an act performed yearly by over 6,000 youths in the United States. This was the act of suicide.

It is not easy for school administrators, teachers, and counselors to admit a lack of foresight and preparedness in dealing with the very difficult issue of suicide. The fact is, however, that most schools are ill-prepared to deal with such a crisis. Few schools have taken a proactive role in resolving the suicide issue before it became one. Perhaps it is human nature to act only after a crisis occurs. Most people wait until their homes are burglarized before making the decision to install deadbolts on their doors and security devices on their windows. Schools are sometimes affected by the same logic. Sometimes they wait too long to act.

A school's planning for a possible suicide crisis cannot be prolonged. The likelihood that a suicide will be completed by a student from our schools, our churches, our businesses, and our communities is greater today than ever before. Preparations to deal with this type of tragedy can no longer wait.

This monograph is, therefore, written to provide teachers, counselors, administrators, and other school staff members with a simple and practical guide to becoming "response-ready" when dealing with suicide. It does not explain the suicide phenomenon, various analytical publications explain the nuances behind suicide.

Instead, this monograph relates the program and experience of one school in Golden, Colorado. It makes no guarantees, but it is hoped that it will serve as a starting point to help many schools prepare to deal with this issue before they are faced with it.

NEA Policy on Student Stress

Resolution C-12. Student Stress

The National Education Association believes that there are increasing mental, emotional, and environmental pressures upon the children and youth of this nation. These pressures—resulting in increased drug and alcohol abuse, violence, vandalism, dropping out of school, and suicide among children and youth—speak clearly to the waste of human potential.

The Association urges its local and state affiliates to support appropriately accredited and licensed mental health and aftercare programs for students and to provide staff development workshops for personnel in direct contact with these students.

The Association further urges local and state affiliates to seek legislative support and publicity for these programs. (80, 89)

1. "RIDDLED, NOT READY"

Many of the students attending schools are riddled with personal and family problems and are not ready for the task of learning. Reports such as *A Nation at Risk* and Boyer's *Carnegie Report* have done little to recognize that students are riddled, not ready. Lost in the reports indicting educational systems and teaching practices is the recognition that self-destructive behaviors are prevalent among youth and affect their willingness to learn. Many of those attending school are so riddled by their problems that they need psychiatric assistance. The number of these "troubled" young people has grown significantly. In fact, the National Institute for Private Psychiatric Hospitals reported that admissions in adolescent treatment centers increased by 450 percent in the last five years (1).^{*} Ample reason exists for educators to be discouraged.

A review of recent periodicals, research reports, and media documentaries reveals the same conclusion—young people are in trouble. Despite eloquent efforts on the part of schools with drug and alcohol programs, driver education, sex education, and other prevention programs, the youthful casualties continue to increase. A 1987 public television production entitled "Generation at Risk" alarmingly reported that while life expectancy of most Americans increased over the last ten years, it decreased for adolescents (2). In an age of extraordinary scientific and medical advances, such a fact seems to contradict rational thinking.

What else are the periodicals, research reports, and media documentaries revealing? Consider the statistics about adolescents.

Currently, over 9,000 teens are killed yearly in motor vehicle accidents (3). Accidents are, in fact, the leading cause of death among teens. In 1986, 52 percent of fatally injured teen drivers were found with alcohol in their bloodstream, and an estimated 3,538 teens died in alcohol-related accidents (4).

Approximately 43 percent of high school seniors reported using marijuana in 1985 (5). In 1986, over 92 percent of all seniors had used alcohol (6). One in 20 seniors uses alcohol or marijuana daily (7). A recent U.S. Public Health Service survey concluded that 15 percent of eighth graders had used marijuana, and that more than one-third of high school sophomores had tried the drug. Almost 80 percent of eighth graders and 90 percent of tenth graders had consumed alcohol in the past month (8).

One of six babies born in the United States is born to a teen parent.

^{*}Numbers in parentheses appearing in the text refer to the References beginning on page 53

Four of 10 teens will become pregnant as a teen (9). Each year 1.5 million teens become pregnant (10). If current trends continue, it is estimated that 40 percent of the girls who are 14-years-old today will be pregnant at least once before they reach 20 (11).

In 1984, one in four of all reported abuse cases in the United States were children ages 12 to 17. Nationally, 14 percent of all children under age 18 are victims of abuse each year (12). In 1988, child abuse deaths increased by 5 percent nationwide (13).

An estimated 10 to 30 percent of teens in the United States are affected by obesity. An estimated 1 percent of girls between 12 and 18 become anorexic every year. Nationally, between 5 and 25 percent of adolescent and young females practice bulimia (14).

More than 700,000 students drop out of U.S. high schools each year. Nearly 300,000 are chronically truant. Twenty-seven percent who enter eighth grade do not finish high school (15).

Unfortunately, suicide statistics are even more discouraging. The most recent statistics available by the National Center for Health Statistics indicate that more than 30,000 Americans committed suicide in 1986. Of these, more than 5,000 were teenagers (16).

On a national level, suicide is now the second leading cause of death among teens. During the last 20 years, teen suicides have increased by 300 percent (17). It should be noted that suicide estimates are difficult to make since underreporting occurs. For example, local coroners are sometimes hesitant to declare a death by suicide because of insufficient evidence or in order to protect families from additional suffering.

Estimates place the number of young people attempting suicide at 500,000 each year (18). An average of one suicide attempt per minute occurs in the United States (19). The National Adolescent Student Health Survey conducted by the American School Health Association reported that one of every seven adolescents reports having attempted suicide (20). Females "attempt" more often than males, but males "complete" at a higher rate and in more lethal ways (21). Three out of four completers are boys (22). Sixty-two percent of teenagers who die, kill themselves with a gun (23).

Between 1968 and 1976, the rate of suicide among 10- to 14-year-olds increased by 33 percent. Between 1976 and 1982, data suggests that the increase may be as high as 41 percent (24).

According to a Colorado Department of Health research report, in 52 percent of the cases nationwide, the suicide attempt followed a problem with parents; 30 percent of the cases involved a member of the opposite sex; 16 percent of precipitating events involved siblings, and 15 percent involved peers. Only 5 percent occurred as the result of drugs, hallucinations, or other psychotic disturbances (25).

The number of American children participating in self-destructive behaviors places schools in a precarious position. Today's schools are filling a void left by many families and communities. The educator's role has been dramatically changed. Teachers, counselors, and administrators are finding themselves in the role of surrogate mothers and fathers. Schools are being asked to complete the tasks that others are unwilling or unable to perform. Although educational changes must occur, it is imperative for schools to empty their pockets of the notion that "we can fix and save all." This is not to say that schools hold little or no responsibility in responding to the self-destructive behaviors that afflict many students. It is becoming apparent, however, that educators cannot combat the effects of social ills and perform their primary academic mission at the same time.

Schools cannot tackle the problems of society alone, just as parents cannot solve all their children's problems by themselves. For example, although some admirable gains have been made by schools through efforts in drug/alcohol education, driver education, and sex education, the problems persist and continue to grow. More youths are involved in drugs and alcohol today and at an earlier age than ever before. More youths are killed in auto accidents today than ever before. More teenage girls are pregnant today than ever before. Expectations about what schools can resolve must be modified. After all, children do not attend school 24 hours a day, or seven days a week, or 12 months a year.

Educators cannot afford to deal with reversing the youth suicide trend in the same manner as that used with other societal problems. It is crucial to treat adolescent suicide as a community problem rather than as just a school problem. The real challenge for educators across the nation will be in the involvement of communities in the resolution of the teen suicide epidemic.

2. THE ROLE OF THE SCHOOLS

The old saying "Damned if you do; damned if you don't" is commonly used to describe dilemmas faced daily by those working in schools. When referring to the problem of suicide, however, it has recently become evident that administrators, counselors, teachers, and other staff members are *more* damned if they don't.

For this reason, it is important to note that schools can play an important role in reversing the tragic results of youth suicide. Between 70 and 75 percent of the people who attempt or complete the act of suicide tell someone about their intentions (1). When considering this fact, it is easy to realize the tremendous impact schools can have in prevention. The role of the school is a significant one.

The inherent nature of the school setting lends itself to interventions that may not be possible elsewhere. Since the school provides an ideal setting of interaction between children and adults, opportunities exist for responding to many youth problems, but especially those relating to self-destruction.

IN LOCO PARENTIS

No legal term describes the role of schools more accurately than "in loco parentis." School officials and employees exercise their responsibilities in loco parentis. This Latin term meaning "in place of the parent" compels professional staff and other school employees to act in a "reasonable and prudent manner." Generally speaking, the limits of the in loco parentis role have been defined by case law rather than legislative mandates. Since what is reasonable may change from one set of circumstances to another, it is difficult to clearly define the concept's limits.

Consequently, educators are obligated to perform as would "reasonably prudent persons under the same or similar circumstances." Educators, however, hold a responsibility that has higher standards of care than those of the average person. This responsibility carries a vast burden for administrators, counselors, teachers, and other staff under threat of liability. For example, some argue that school counselors may be held to a different standard of care than classroom teachers because of their training and certification requirements. The same may hold true for principals.

An additional consideration is the question of negligence, an element of torts or wrongful acts. The school has a duty to prevent injuries that it can reasonably foresee or anticipate. Culpable negligence occurs when

one fails to exercise the degree of care considered appropriate by the specific circumstances and that a person of ordinary prudence in the same situation and with equal experience would not have omitted. There is legal consensus that when school officials or employees "reasonably foresee" that an injury may occur if a specific condition is not corrected or preventive action is not taken, a duty exists to do something about it before an injury occurs. If not, liability may be imposed for negligence.

The application of these premises to suicide situations is obvious. For instance, a reasonable and prudent teacher would be able to foresee that a life-threatening situation is likely to exist when he/she reads a student journal revealing a young man's plan to commit suicide. Once this danger is foreseen, the teacher and other school officials must take immediate steps to alleviate the condition causing danger. Another example relates to school counselors. In his book, *Youth in Crisis*, Dr. Thomas Barrett explains that a counselor is negligent when he/she fails to refer a case of a potential suicide victim that he/she is not equipped to help or treat (2). These examples serve to emphasize the importance of contingency plans, which will be discussed in later chapters.

The most common lawsuits filed against teachers and school officials are in the area of negligence. Since the student is the "ward" of the school and its employees, a limited legal obligation exists to remove dangerous conditions and to aid and protect him/her.

THE KELSON CASE

A recent court decision should concern many educators. In 1985, the Ninth Circuit Court of Appeals held that the parents of a child who committed suicide could bring action against the school. In this case (*Kelson v. the City of Springfield, Oregon* [767 F.2d 651]), the parents brought a suit under the federal law (42 U.S.C. Section 1983) that provides for money damages when a person or entity, acting under the state law, violates the plaintiff's constitutional rights. Although the trial court dismissed the original suit, the appellate court reversed that court's decision. The Ninth Circuit Court of Appeals held that the Kelsons had a constitutionally protected right to the "continued association of a parent with her child" and that the case could be filed. (The final resolution of this case is not known to the author at press time.)

Decisions regarding these matters are rendered on a case-by-case basis and are strongly dependent on circumstances. For example, at least one other federal court has rejected the Kelson holding (*Cortez-Quinones v. Jimenez-Nettleship*, 842 F. 2d 556 [1st Cir. 1988]). The Kelson case has simply established a precedent in litigation regarding the suicide issue.

The details of the Kelson case are interesting. Initially, Kelson was unusual because the suicide occurred in the school. Most occur in the home. After confronting a teacher with a .38 caliber revolver, 14-year-old Brian Kelson was taken to a room where the vice principal was present and where the boy showed a suicide note he had prepared. The student was allowed to keep the gun in the waistband of his pants while he went to the bathroom where he fatally shot himself.

In another case, the parents of an eighth grader in Milford, Connecticut, filed a lawsuit in the New Haven state court against the school claiming that teachers and their supervisors "failed to provide parents with adequate and timely information" about their son's potential self-destruction. Newspaper headlines read, "Parents Blame School in Lawsuit for not Preventing Son's Suicide" (3). The outcome of this case is yet to be resolved.

Such cases are indicative of a growing and disturbing trend. So strong is the fear of litigation that five states (California, Florida, Louisiana, New Jersey, and Wisconsin) have passed legislation requiring schools to have suicide prevention programs. Other states are currently planning such programs. Certainly the Kelson case has confirmed the possibility of further litigation against the schools. Accordingly, schools must take another look at their policies regarding suicide situations.

THE IMPLICATIONS

The handling of potential suicides requires care. It is imperative, consequently, to provide appropriate training for those employees dealing with these situations. A referral process should be established, and a system that allows collaboration should be maintained. Contingency procedures should be developed and records must be kept.

In states where legislative mandates or board policies exist for suicide prevention programs, school officials and employees are not exempt from the responsibility to act under the "reasonable and prudent" standards. The consequences of failing to comply with statutory mandates, however, are going to be different from a negligent act resulting in an actionable injury such as the death of a child. Suits may result, for example, from the failure to comply with the statute even if injury has not occurred. These suits may also seek an injunction directing that the school implement the mandate.

THE LIMITS

The limitations of the school's role are worthy of discussion. *Most important, schools are not in the business of therapy; they are, instead, in*

the business of education. For this reason, it may be claimed that the scope of responsibility for schools is limited to a response to the problem. This may be more consistent with the *in loco parentis* obligation that compels teachers, counselors, administrators, and others in the confines of the school setting to take "reasonable and prudent" actions when dealing with suicide.

It may be argued that the school's response role is limited to what may be termed "Level 1 Intervention." Levels 2 and 3 relate, respectively, to formal therapy and hospitalization/treatment. It is clearly evident that neither the mission of the schools nor the resources available to them allow for formal therapy or treatment of suicidal youths. Level 1 Intervention relates to three activities for the school and its employees—*detection, assessment, and referral.*

Detection refers to the school personnel's responsibility to recognize the signs of trouble. It, of course, requires that parents, teachers, counselors, administrators, secretaries and aides, custodians and other school personnel, and most importantly, students, be trained in recognizing the signals and myths of suicide.

The training sequence is as important as the content of the training. It is imperative that adults receive suicide prevention training prior to students. The reason is simple. If students are trained first, their level of awareness is heightened, resulting in an increase of referrals to adults who are not ready to deal with a potentially dangerous situation.

Suicide prevention training can occur through in-services, workshops, recertification classes, seminars, regular classroom instruction, and assemblies that are followed by small group discussions. Training must also involve the dissemination and discussion of steps to be taken when a problem has been detected.

After detection takes place, an *assessment* of risk by appropriately trained staff, usually counselors, should take place. Assessment is done through an inquiry or questioning of the subject. Determining low, moderate, or high risk of suicide is helpful in deciding the next step. It should be noted that those participating in assessment interviews should receive appropriate crisis intervention training.

Finally, after a proper assessment takes place, an appropriate response needs to be exercised. This response or *referral* typically includes contact with a parent, local police, paramedics, county social services department, or mental health center. Incidentally, a parent contact is best made personally rather than by phone. Parents should be contacted in all cases unless it is damaging to the child or is likely to cause a suicide attempt.

THE SOLUTION

Schools cannot escape the fact that they are in an excellent position to act. School-based programs need to be developed so that effective responses to the suicide epidemic can be implemented. A comprehensive suicide intervention program should include the following four components:

1. Activities for Prevention
2. Procedures for Suicide Referrals
3. Procedures for Suicide Attempts
4. Procedures for Suicide Completions

Each of these components plays an important part in the readiness of the school to deal with the problem in a prudent manner. The most appropriate time to prepare for this terrible tragedy is *before* it occurs. The groundwork necessarily must involve discussions with students, teachers, parents, board members, counselors, administrators, and community members regarding reasonable actions to be taken. The neglect of the suicide problem by a school invites panic and desperation, which in turn lead to irrational decisions at the most inopportune time.

It is, furthermore, crucial to coordinate preventive and procedural efforts with other schools within an attendance area and district, churches and temples, parent groups, police, community organizations, social services, private therapists, and mental health clinics. Such an approach ensures that youth suicide is treated as a community problem rather than as a school problem.

3. BECOMING RESPONSE-READY: THE CRISIS TEAM APPROACH

The previous chapter discussed the necessity for a contingency or intervention plan. Such a plan must be carried out by an entity within the school that is capable of fulfilling its responsibilities—the “crisis team.” The crisis-team approach is not a new idea, but it is one of the most effective tools that can be utilized to combat suicide situations.

WHO SHOULD BE INVOLVED?

The basic goal of the crisis team, or intervention team, is to respond to the problem of suicide. The team is initially composed of teachers, students, parents, counselors, administrators, school nurse, school social worker, and psychologist, all of whom have the responsibility to implement a school intervention program. After the development and implementation phases, the crisis team is reduced to those who are free to act during a crisis situation—including counselors, administrators, some teachers, school nurse, social worker, and psychologist.

In the initial stages of developing an intervention plan, the involvement of teachers, students, and parents is very critical. The input of these individuals can be extremely helpful in the design of programs and procedures; therefore, their recommendations cannot be ignored. During the actual crisis intervention, however, it is important to realize that teachers will likely be involved in carrying out their teaching duties. Students will be in class. Few parents will be at home, most will be at work, and some will be unavailable. This is not to say that there will not be times when their involvement is crucial. There may, in fact, be situations when the presence of these parties is necessary. In most cases, a referring teacher becomes a member of the crisis team.

CRISIS TEAM RESPONSIBILITIES

After individuals have been recruited to serve on the school crisis team, certain responsibilities must be fulfilled. There are four major functions that any crisis team must carry out.

1. Development/implementation of the intervention plan

As discussed in Chapter 2, a comprehensive intervention plan should contain procedures relating to prevention, referrals, attempts, and com-

pletions. It is necessary to develop reasonable and prudent school procedures relating to each of these components. Moreover, it may be as important to determine who will be responsible for carrying out a particular procedure as well as back-up staff.

The development of a comprehensive intervention plan requires much time. It is, however, the most critical activity of the crisis team since the specific procedures outlined will rule the behavior of personnel when a suicide situation arises. The design of crisis procedures provides an avenue of proactive activity rather than reactive exertion at the time of crisis.

The implementation of the crisis procedures should be completed by those who are in a position to act. Typically, counselors, administrators, nurse, social worker, and school psychologist are free to act in times of possible crisis. For this reason they should be the ones involved in carrying out the demands of the plan. Schools without counselors should provide training for available professional staff.

Special consideration should be given to the issue of confidentiality. Strict procedures should be followed in order to protect the suicidal person's privacy. Accessibility should be carefully restricted. Crisis teams will find it helpful to become familiar with the Family Education Rights and Privacy Act and its guidelines. This act, passed in 1974, is also known as the Buckley Amendment. Provisions pertain to access, dissemination, and correction of student records (1).

2. Coordination with community resources

Collaboration with resources outside the school will enhance the effectiveness of each component in the intervention plan. The crisis team should first compile a list of community resources, including mental health organizations and institutions, therapists, law enforcement agencies, social services, medical professionals, churches, youth organizations, feeder schools, local newspaper, and other interested parties. Representatives from each of these groups should then be invited to the school to discuss their services and limitations. Their assistance should be recruited and ultimately become part of the intervention plan.

3. Education and Training

The crisis team should coordinate education efforts intended to increase the level of awareness of teachers, counselors, administrators, all other school personnel, parents, community members, and students. Special training in-services should deal with detecting suicide signs and signals as well as procedures to be followed. Crisis team members must receive additional training in school "crisis intervention." Parent/Community seminars can be easily planned and can take place with little or

no cost since mental health organizations and professionals are usually willing to provide such a service without a fee.

A very simple task that is commonly overlooked is the compilation of printed and audio-visual materials that can be made available to those wishing to know more about suicide. (See Appendix G.) These resources can easily be made available through the school library or the faculty professional library. Resources should be shown only after proper readiness and preview.

4. Program and maintenance

Important maintenance activities for the crisis team include a yearly review and evaluation of the effectiveness of the intervention plan, revision of the procedures, and the training of new staff members. Every two years, it may be necessary to reacquaint the crisis team with new community resources so that effective cooperation can be renewed. Additionally, continued efforts should be made to educate community members.

OTHER APPROACHES

Additional approaches to suicide crisis intervention exist. For instance, some small schools have only one individual, usually a counselor, who has been assigned the duties of a crisis manager. Other schools have crisis teams composed of teachers who have received special intervention training and who give up their planning periods to serve as crisis managers. Some school districts have a central administration intervention team that travels from one school to the next during a school crisis. Others include strong peer counselors as part of their intervention teams. There are also schools that rely on crisis teams consisting of local mental health professionals. Some use a combination of all the above methods. In any case, local needs and available resources generally rule the approach used by a school building. Although many of these approaches have been successful, the in-house crisis team is a more tenable plan because it allows for more timely responses. The in-house crisis team members are likely to have better rapport with students and staff members of the school and, as a result, may be able to act more quickly than other models.

Finally, it is noteworthy to indicate that the crisis team approach has some spinoff applications. With very few modifications, a crisis team can develop contingency plans for accidental deaths or homicides, as well as for other self-destructive behaviors such as drug and alcohol abuse and eating disorders.

4. THE CONTINGENCY PLAN

This chapter focuses on the contingency plan also known as a school's suicide intervention procedures. It details the intervention plan of Golden High School, a Jefferson County Public School located in Golden, Colorado. Golden High School is a four-year suburban school near Denver that serves approximately 1,400 students. It has a very small population of minority students but its students come from a wide range of socioeconomic levels.

As mentioned in the Preface, four student suicides occurred during a 21-month period in the Golden High School community. After the first suicide in 1985, procedures were quickly developed by school personnel; they were used and revised before and after ensuing suicides.

In 1986, the state of Colorado was struck with a youth suicide epidemic. The Colorado Health Department reported 51 youth suicides during that year (10 more than the previous year). Six were below the age of 14. The Jefferson County area, a community with the highest population of 15- to 19-year-olds in the state, was hit hardest with 11 suicides (1).

During 1987, youth suicides persisted in the state. The number of suicides, however, decreased to 33. Ten of the victims were under the age of 14, according to the Health Department (2). Complete figures for 1988 are not yet available. Among the dead in 1988, however, was a nine-year-old (3).

THE PLAN

The Golden High School suicide intervention program is a comprehensive plan. A "Response Team" or "RT" composed of five counselors, four administrators, one school nurse, and one school social worker has the responsibility to implement the program. Students, teachers, parents, and other community members participated in the initial planning phases of the intervention procedures.

The contingency plan has four major components—response for prevention, response to suicide referrals, response to suicide attempts, and response to suicide completions. It was first published by the National Association of Secondary School Principals.* It is reprinted here by permission. Portions of the reprinted suicide intervention procedures have been revised in order to improve the plan.

* "Establishing a Suicide Prevention Program. One School's Response," by John A. Vidal. *NASSP Bulletin*, vol. 70, no. 492, October 1986. Copyright © 1986 by the National Association of Secondary School Principals. Reprinted with permission.

Response for Prevention

The focus of prevention is detection. Detection is most effective through special training seminars and sessions. Many therapists and mental health agencies are willing to provide training at minimal or no cost to the school.

Members of the Response Team:

- Design and conduct training for faculty members, administrators, counselors, students, secretaries, aides, custodians, and any other appropriate persons. Training must include information about facts and myths of suicide, available alternatives and resources, and data about school procedures.
- Hold parent and community seminars.
- Train special peer (student) counselors.
- Confidentially identify high-risk students.
- Compile a list of resources (people and materials) within the community.
- Hold a networking meeting with community agencies (i.e., police, mental health, social services, school district's special services) in order to clarify each organization's roles and limitations in the intervention process.
- Speak to the school publication sponsors about establishing consistent and appropriate memorial practices in the yearbook and newspaper. The local newspaper should be invited to participate in the discussion.

Other ideas should be considered as a supplement to basic responses for prevention. For example, a fund should be established for the purpose of sending school personnel, students, and parents to local suicide prevention conferences and seminars. In addition, a newsletter item should be written about the school's intervention procedures so that parents are informed about the process. A confidential intervention form should also be developed so that records of action are kept. Finally, the development of a "contract" in which the suicidal youth agrees not to harm him/herself may be helpful if used to complement other interventions.

Response to Suicide Referrals

The handling of possible suicide victims is contingent upon the willingness of students and staff members to commit themselves to seeking assistance. Willingness to make referrals depends on the clarification of procedures to all involved in the process.

Once a referral has been made, a systematic intervention procedure should be followed. These procedures should entail the following:

- Teachers, students, or other persons refer possible suicide victim to a Response Team member who becomes the "case leader."
- The case leader or Response Team member meets with the troubled student to inquire about the problem and assess the situation.
- The case leader then consults with another Response Team member at an appropriate time to determine the next step (i.e., contacting parents, social services, police, and/or the local mental health department, continuing to work with the student or taking other appropriate action). If appropriate, the case leader should have the youth sign a "contract" agreeing not to do harm to him/herself.
- The case leader reports back to the person who made the original referral to discuss action taken.
- If appropriate, and after consultation, the case leader notifies the student's teachers and other staff members stressing confidentiality.
- A Response Team member is selected to maintain contact with the student and others involved.
- In cases where parental resistance exists, Response Team members should collaborate with the principal or a designee about a decision to file charges against the parent/guardian for "dependency neglect" on the grounds of refusing to provide adequate health care.
- A Response Team member writes a record of the case to place in the confidential RT file.

Response to Attempts

The family of someone who attempts suicide often feels guilt and shame. If the family knows that a school has a helpful, nonthreatening manner of dealing with suicide situations, however, it is more likely to reveal that a son or daughter made an attempt. The school's response to suicide attempts should be based on making the student's return to the school comfortable. A comfortable transition back to school can provide preventive benefits.

Assuming that the student may be absent for a period of time (perhaps two to four weeks if hospitalized), the school should be guided by these steps:

- A Response Team member should be selected to call the parents and verify the situation, probable absence time, etc.
- When the school learns about a suicide attempt, the assigned counselor will notify the student's teachers and administrator, and emphasize confidentiality.

- A Response Team member contacts the student's teachers and requests appropriate assignments.
- A Response Team member monitors the student's friends, and/or follows up on other students who may be perceived to be "risks."
- A Response Team member works with parents and/or other professionals involved with the student, providing progress reports and other necessary information.
- A Response Team member establishes and maintains periodic contact with the student who attempted while he/she is away, and informs him/her of the latest developments in the school (i.e., latest team scores, special events, school news).
- A Response Team member, upon the student's return, maintains periodic contact with him/her and parent, and staff members when appropriate.
- A Response Team member writes a record of the case to place in the confidential RT file.

Response to Completions

It is extremely difficult to gauge the potential effects .. suicide may have on a school. A school's reaction may be different depending on the victim's popularity, the time of the year, the violent nature of the death, and other unknown reasons. The fear that talking about the suicide might lead to additional suicides keeps many from responding properly. It is, nevertheless, imperative to respond in a manner that does not glorify the suicide act and, at the same time, allows the grief process to take a natural course.

Part or all of the following incident reaction process should be used after a student suicide has been verified as true:

- Call all administrators, counselors, the student's teachers, remaining teachers, school social worker or psychologist, nurse, and campus supervisor. Inform them about the incident and request their presence at an emergency faculty meeting. (RESPONSIBILITY: ADMINISTRATION)
- Hold an emergency faculty meeting to discuss procedures for the day, and relay the facts about the suicide. Inform teachers to allow students to talk about the suicide individually, as a group or class, and send those students having greater difficulty to the counseling center to see a Response Team member or other available personnel. (RESPONSIBILITY: ADMINISTRATION)
- **DO NOT MAKE A PUBLIC ADDRESS ANNOUNCEMENT OR HOLD AN ASSEMBLY.** This avoids the glorification of the act as well as mass confusion and hysteria.

- During the day of the crisis, establish "grief groups" composed of the victim's network of friends. Note the names of students in the groups and assign them a counselor who will work with them individually during the succeeding days. The counselor and a Response Team member will then decide if further referral is needed for the grieving student. (RESPONSIBILITY: COUNSELING)
- Alert feeder schools in which the victim's siblings are enrolled. (RESPONSIBILITY: ADMINISTRATION)
- Call the local mental health department and/or the school district's student guidance services office to alert them to the incident, and if necessary, request a team of counselors to come to the building to work with school personnel and students for an appropriate number of hours or days. (RESPONSIBILITY: ADMINISTRATION)
- Contact the victim's parents in order to offer any assistance and determine additional action. (RESPONSIBILITY: ADMINISTRATION OR OTHER APPROPRIATE PERSONNEL)
- If appropriate, request that the family hold services after school hours. Avoid agreeing to parental request to hold services at the school. (RESPONSIBILITY: ADMINISTRATION)
- If appropriate, announce funeral date, place, and time. (RESPONSIBILITY: ADMINISTRATION)
- Clean out the victim's locker. If a suicide note or other evidence is found, notify the police immediately. (RESPONSIBILITY: ADMINISTRATION)
- Officially withdraw the victim from the school enrollment file. Collect any school books or materials. Any personal items should be returned to the victim's family. (RESPONSIBILITY: ADMINISTRATION AND COUNSELING)
- Have the mental health department or other appropriate personnel conduct a voluntary "critical incident review" with the staff within three days. (A critical incident review is a debriefing session with the school staff that reviews information about the suicide victim as well as other issues relating to feelings, process, etc.) (RESPONSIBILITY: ADMINISTRATION)
- If necessary, call suicide experts to set up a symposium or seminar on a later date for students, parents, school personnel, or other appropriate individuals. (RESPONSIBILITY: ADMINISTRATION OR RESPONSE TEAM MEMBERS)
- If deemed appropriate, place an item in the school newsletter explaining the procedures used in dealing with the suicide, providing information about suicide, hotline numbers and advice, and inviting all to attend any planned suicide symposiums or seminar. (RESPONSIBILITY: ADMINISTRATION)

- Prepare a statement for the media with information regarding actions taken by the school. Avoid furnishing personal information about the victim or the family. Designate only one spokesperson to handle all media inquiries. (RESPONSIBILITY: ADMINISTRATION)
- Conduct followup sessions with the victim's friends. (RESPONSIBILITY: COUNSELING OR OTHER APPROPRIATE PERSONNEL)
- Write a report of the case for the confidential RT file. (RESPONSIBILITY: RESPONSE TEAM MEMBER)

WHO SHOULD BE READY?

It is certainly not the intention of this chapter to connote that an intervention plan should be developed only by a senior high school. On the contrary, contingency plans are necessary to develop in both middle and junior high schools as well as elementary schools.

The logic behind developing plans for all schools is simple. Although the majority of school-aged suicides occur among 15- to 19-year-olds in secondary schools, the suicide rate for children under 15 years of age has increased by nearly 800 percent (4). In 1982, for example, 200 suicides were reported nationwide for children under the age of 15 (5).

It is additionally important for middle or junior high schools and elementary schools to implement contingency plans because often the siblings or friends of students who attend these schools are affected by the death of a student attending the local high school. These students need help in dealing with their grief as well.

CAN PROGRAMS WORK?

School-based programs have already demonstrated success in reversing the teen suicide rate. The Fairfax County Public School District, in the Washington, D.C. area, which serves over 125,000 students, initiated one of the first school-based suicide prevention programs in the nation. (See Appendix G.) In response to 20 adolescent suicides within a one-year period, the Fairfax County schools, with assistance from community organizations, developed a comprehensive adolescent suicide prevention program, which includes training and early identification of those students at risk. In one year, the program reduced teen suicides from 20 to 2 (6).

An extensive suicide education program developed by Thomas Barrett claims significant suicide reductions in participating schools of the Cherry Creek Public Schools District in Aurora, Colorado. The Cherry Creek

Schools Prevention Program trains school personnel and students in suicide myths, facts, and signals (See Appendix G). A curriculum providing eighth and ninth graders with information relating to suicide was also implemented.

Another exceptional program, the Adolescent Suicide Awareness Program (ASAP) was initiated by a community center. The South Bergen Mental Health Center of Lyndhurst and Hackensack, New Jersey, developed ASAP in 1980. (See also Appendix G.) ASAP serves youth through extensive adolescent suicide prevention education and a strong partnership between local schools, communities, and mental health professionals.

A final program worth noting was developed by the 26-member Wingspread Task Force on Suicide Prevention Efforts composed of prominent educators, researchers, and suicidologists. The Task Force, which was organized by the American Association of Suicidology (AAS) (7), developed a model suicide prevention program for schools to use throughout the nation. The program concentrates on life-skills training, detection of at-risk students, and the establishment of procedures for school response.

Essentially, the wheel does not need to be reinvented by schools throughout the country. Many effective programs exist in U.S. schools (see Appendix G). School officials can save much time on the development of policies and procedures by consulting individuals in already established programs. Once familiar with other programs, crisis teams can adjust programs to fit local circumstances and needs.

5. MISTAKES TO AVOID

It is difficult to determine if a school has been successful in averting a student suicide. Mistakes, however, are obviously more easily identified. This chapter concentrates on avoiding common mistakes that can be made by schools combating student suicide. School personnel can improve their effectiveness by refraining from making twelve common errors.

TWELVE MISTAKES TO AVOID

1. Avoid Waiting for a Crisis to Occur Before Planning

Mistakes are more likely to occur when decisions are saved for crisis times. In order to deal with suicide situations, schools should resist tendencies to postpone planning. After a student suicide, for instance, all parties are involved in the very emotional time of grief resolution. This is the most inopportune time to be determining contingency plans. In times of crisis, decisions are more likely to be characterized with irrational feelings. The time to plan for suicide prevention, referrals, attempts, and completions is before crisis situations arise. Rational dialogue regarding what should happen in a suicide situation must occur before the crisis. Schools should avoid waiting for suicides to occur before making the decision to act.

2. Avoid Not Talking About Suicide

The most significant block keeping schools from acting on the suicide problem is the fear that talking about it will cause suicides to occur. Several recent studies claim that television and newspaper coverage of suicides tends to increase their occurrence. Some studies have also claimed that the opposite is true. In either case, these studies have only helped to increase the fear of school personnel, parents, students, and community members that talking about suicide is not a good idea.

Nothing can be further from the truth, however. Talking about suicide can be an excellent tool for prevention. Perhaps the debate should be centered not on whether schools should talk about suicide, but rather, on *how* schools should talk about suicide. There is general agreement among many therapists that talking about this subject can provide effective prevention.

Another related problem with which schools must contend is the idea that there may be little choice but to talk about suicide. This is especially true if a suicide has been completed by a school's student. In such a case, the school faces the risk of allowing the suicide to speak for itself if school personnel refuse to talk about it. Additional suicides may occur if the school does not help students deal with the death of a classmate. A school invites panic and irrational behavior if it neglects to deal with suicide. This mistake can be a deadly one.

Talking about the subject is the most effective way of breaking down suicide myths and feelings as well as allowing all involved an opportunity to learn how to manage the problem.

3. Avoid Preparing Students Before Adults

As mentioned in the discussion of the training sequence in Chapter 2, adults in the school setting should be prepared for suicide intervention before students are instructed. Preparation comes in the form of training, which is done with the purpose of increasing the awareness levels of those who attend and work in the school. Students whose level of awareness regarding suicide has been heightened tend to increase referrals to adults within the school. When students are prepared and adults are not, confusion exists, resulting in lack of action on the part of adults. This lack of action unfortunately will be interpreted by students as a lack of concern on the part of teachers, counselors, administrators, and other school staff. To avoid the possibility of this unfortunate condition, schools must make sure that the adults receive preparation before students do so that they can respond appropriately to student referrals.

4. Avoid Showing Films/Videos Without Processing

Teachers, counselors, and other school personnel should exercise care in showing films and videos about suicide to students. Although films and videos are effective tools for suicide intervention training for students, adults should take the time to preview materials and provide appropriate activities that allow for the processing of information. Proper processing of audiovisual materials includes some anticipatory activities before materials are presented, as well as followup discussion. Films and videos should not be presented alone without first preparing students for their showing and without allowing for student-teacher interaction about what is seen. Parental permission should also be sought.

Adults utilizing such educational materials should also be trained in order to avoid heightening anxieties about suicide. An uninformed adult can harm a suicide prevention program by confusing students about the subject matter.

5. Avoid Public Address Announcements About the Suicide

An announcement regarding a suicide may be the quickest way to inform the school's personnel and student body about the tragic death of one student, but it is certainly the least beneficial way to do so. Such a public address announcement tends to glorify the suicide act as well as invite mass panic and hysteria. Most importantly, however, such an announcement is a very insensitive way to inform the friends and teachers of a suicide victim.

Announcements about student suicides can be made effectively if, before the beginning of the school day, school personnel hold an emergency meeting with staff members instructing them to announce accurate details in class. If an emergency faculty meeting is not possible, then a memorandum should be delivered by school officials to each teacher with announcement instructions and further action to be taken. This strategy is outlined in the contingency plan in Chapter 4.

6. Avoid Assemblies for Announcement Purposes or Discussion

As with public address announcements, holding assemblies to announce or discuss the suicide of a student also invites panic and mass hysteria. Such assemblies are also insensitive in informing survivors about the death of a close friend or former student. Some at-risk students may view such an assembly as a very powerful way to receive the recognition or attention they need. In fact, such actions may encourage additional suicides.

An all-school assembly designed to discuss the suicide problem is also not a very effective method for facilitating healthy student exchanges about the subject. Information and discussion about suicide can be best done in small groups. Small groups offer a safer environment for students to express their feelings freely and receive answers to their questions.

7. Avoid Suicide Counseling Groups

School personnel, especially counselors, should avoid forming "suicide groups." The obvious connotation of such groups is that its members constantly discuss suicide. This counseling approach may fuel the feeling that suicide is an acceptable alternative to solving problems.

Counselors and other school personnel may be more helpful to students by supporting counseling groups that focus on coping skills, decision-making and problem-solving skills.

8. Avoid the "Wall of Death"

A natural tendency for classmates and teachers of the suicide victim is to resolve their grief by placing a plaque on a wall in a school hallway in memory of the dead student. Such an action is illogical since it glorifies the suicide. It gives students the impression that they must die in order to receive recognition or attention. A "wall of death" is an inappropriate recognition of an irrational act. A better investment of time is in the recognition of the living.

9. Avoid Inappropriate and Inconsistent Dedication Pages

Typically, a school's newspaper and yearbook devote a dedication page or section to a student who has died. This action is appropriate, but publication sponsors must be careful when the death of a student was by suicide. It is important not to glorify the suicide by devoting an inordinate amount of space to the victim or by detailing how the death occurred. It may be more appropriate to report the incident as a death and a loss that will be missed. The Columbia Scholastic Press Association recommends that the best way to cover such incidents is to place the name of the student, birthdate, and death date next to the portrait (1). The Press Association further suggests that deaths not be featured in the opening or closing of the yearbook, and that the report emphasize what the individual did while living. Incidentally, some school yearbook publishers such as Herff Jones and Jostens/Autrey Brothers have developed guidelines pertaining to suicide coverage. Sponsors should consult their yearbook companies for this information.

Furthermore, it is important to maintain consistency in every dedication page, report, or photograph about a suicide victim. Publication sponsors and their students may be tempted to provide more space, greater detail, and larger photographs of suicide victims who may have been very popular students. When this happens, conflicts may arise in the school involving the friends of less popular suicide victims who feel hurt over comparatively less attention and coverage for their dead friend. It is more rational to maintain a consistent policy for treating this matter.

10. Avoid Funeral Services at the School

There may be times when the grieving parents of a suicide victim will request that the school allow services to be conducted on the premises. School officials are advised not to allow this to happen. A church or synagogue is a more appropriate place to hold these services. In addition, the family may be unknowingly risking embarrassment and additional

suffering in the event of a low student turnout at the school services because many classmates did not know or care about the dead student.

11. Avoid Telling All to the Media

The completion of a suicide by a student from a particular school will attract media attention. It is important that information disseminated by the school be as consistent as possible and cause no further embarrassment to the victim's family. This can easily be accomplished by directing all media inquiries to one person in the school—either the principal or a designee.

The suicide of a child exposes the family to incalculable suffering, guilt, and despair. A school could add to the turmoil experienced by the family by providing specific details of the suicide method, by speculating about the reasons for the suicide, or by revealing unflattering reports about the victim's personal habits. Consequently, it is best for the school to furnish general information about the victim and focus on what has been done to help the "survivors."

12. Avoid the Quick-Fix Approach

Inviting a "suicide expert" to address the school staff, parents, and students does not constitute effective management of a potential suicide crisis. Effective planning includes deliberate activity specifically designed to deal with all aspects of the suicide crisis—prevention, referrals, attempts, and completions. A one-time shot may only worsen the situation.

As previously discussed, schools have a limited legal responsibility in the prevention of student suicides. This responsibility also includes dealing with the contagion effects of suicide. After the suicide of a student, the possibility that peers from the same school will kill themselves increases significantly. It is crucial, therefore, to avoid the types of activities that might obscurely encourage suicides, and to find ways to effectively assist those dealing with guilt, anger, and despair.

6. WHAT TEACHERS CAN DO

Teachers can play a very influential role in the prevention and reversal of student suicide. The student contact that teachers enjoy is far more significant and common than that of any other group in the school setting. Teachers are often more aware of the various aspects of a student's life than others. This places them in an excellent position to help.

TEN WAYS TEACHERS CAN HELP

- Take the initiative.

Be a leader in the process of initiating an intervention program in the school. Insist that contingency plans are developed and take part in the design of those procedures.

- Sponsor suicide prevention seminars.

The school faculty as a group can sponsor a community seminar designed to inform the community and encourage involvement. The teachers' professional organization can be helpful in sponsoring and planning such an event.

- Get involved outside the classroom.

Participate in special student groups such as Children of Divorced Parents, and groups for stress management, dropouts, teen mothers, and new students. The number of students who may fit under these categories is significant. These students probably constitute a large portion of the at-risk individuals in the school.

In some cases, particularly in smaller schools or communities where resources are limited, teachers can volunteer one or two hours a week during the school day to participate in managing the school's crisis team. Before such participation occurs, however, these teachers should receive crisis intervention training.

- Be informed and promote being informed.

Help break down suicide myths and misconceptions by providing accurate information to students and parents (See Appendix B.)

- Be comfortable talking about the issue.

If students feel that teachers and other adults feel free to talk about their feelings, then they may also feel the same about theirs. The best prevention is to talk about suicide openly and honestly. If students feel that adults are uncomfortable with the topic, they certainly will not come to them to talk about it honestly or to refer possible problems.

- Act systematically.

Do not assume that every student talking about suicide is suicidal. At the same time, do not dismiss a student's feelings because he/she may be "trying to get attention." Be willing to follow the school's contingency plans and make a timely referral to a crisis team member when faced with a probable crisis.

- Be aware of the signals of suicide.

Teachers should be aware of the content of school assignments. Writing and art assignments can sometimes reveal significant clues about the youth's feelings. When this occurs, approach the student without making accusations and refer her/him to a crisis team member for additional action.

- Listen.

Listening is not just the proper way to gain more information about a student; it also communicates caring. Listening tells students that the adults around them care about them and are willing to take time with them. This is a powerful tool in getting students to trust adults with their problems.

- Provide plenty of positive reinforcement and rewards.

Students who are high achievers and are pressured by higher standards need much more of this type of fuel. Such students are often overlooked in suicide prevention, yet they compose a large portion of suicide completers.

- Help students become better "deciders" and "copers."

Teachers should share decision making and problem solving in the classroom. Great gains can be made in this task if students are allowed to participate in the day-to-day decisions in their classrooms. Students need this type of opportunity at school as well as at home.

Avoid rescuing students from failures, disappointments, setbacks, and consequences. Such "rescues" only deprive students of practicing needed coping skills and disable them in learning about the real world. When teachers and other adults talk openly about their successes as well as their failures, they can help to break down unrealistic notions.

Teacher participation in the reduction of self-destructive behaviors cannot be overlooked. Through teacher involvement, as discussed, gains in the detection and prevention of suicide can be made. The role of teachers as caregivers contributes significantly to the effectiveness of any school intervention program.

EPILOGUE

There is much recent conversation among education groups about the reconstructing or restructuring of American schools. It should be evident that any new attempts to change schools must face the alarming trends of self-destructive behaviors among young people.

Teen pregnancies, drug and alcohol abuse, eating disorders, dropouts, runaways, AIDS, juvenile delinquency, poor health and nutrition, child abuse, incest, and suicide are among the student problems faced by educators throughout the United States. Educators unselfishly continue to serve those students afflicted with such enormous problems with few resources. It is alarming to realize that American society continues to expect the schools alone to resolve the problems that plague many of its young and yet simultaneously produce higher test scores.

Although not all students attending school are riddled with problems, a large portion of them are consuming a significant amount of the time of many educators who are having to deal with the results of the personal and family problems that students face. The art of teaching is now unreasonably expected to include the ability to motivate students who have "other things on their mind" than adding, subtracting, or learning how to properly use a semicolon.

The most important challenge facing schools will be in sharing the ownership of resolving student problems with families and communities. The challenge is greater than earlier because fewer dollars are spent on education from both federal and state governments and taxpayer revolts against providing more revenues for education continue in many communities. Educators have also lost an old ally—parents. Ernest Boyer, president of the Carnegie Foundation for the Advancement of Teaching, found much frustration among teachers he recently surveyed for a new

report, *The Condition of Teaching* (1). Ninety percent of the teachers surveyed said that a lack of parental support was a problem at their schools.

As members of communities and as instructors of young people, educators accept their legal, professional, and ethical responsibilities to students. Educators, however, must do all they can to reverse the public's opinion that schools can "fix it all." Many of the difficulties faced by the youth are family and community problems. Schools can and should help resolve these difficulties, but not alone.

APPENDIXES

DESCRIPTION OF APPENDIX ITEMS

Appendix A. Ten Suicide Signs and Signals

The danger signals are reprinted from *Teenage Suicide: What Can the Schools Do?* by Jerilyn K. Pfeifer, Assistant Professor at Abilene Christian University. As Dr. Pfeifer states, when adolescents give signals, singly or in combination, a crisis may be imminent.

Appendix B. Ten Myths of Suicide

These ten myths of suicide were synthesized by Ralph L. V. Rickgarn in *The Issue Is Suicide*. He utilized works by Blimling and Miltenberger (1981), Resnik (1968), Resnik and Hawthorne (1973), and Shneidman and Farberow (1961).

Appendix C. Staff Training Outline

The staff training outline is a brief sketch of the items that should be covered for a school faculty and staff. It is recommended that every adult in the school receive this training in a three- to four-hour in-service.

Appendix D. Crisis Team Training Outline

The crisis team training outline provides a brief summary of the topics that should be discussed with individuals who are members of a school crisis team. This training *is not* designed for the entire staff—only the crisis team members should receive this eight- to ten-hour training.

Appendix E. "Save a Friend, Share a Secret"

This pamphlet was developed by the Suicide Prevention Task Force for JeffCo Youth. The task force was formed in 1985 to combat a rash of youth suicides in the Jefferson County (Colorado) community. Task force members included clergy, mental health personnel, police, educators, and other individuals from government agencies and private industry. Among its most productive projects was the composition of this pamphlet designed for teenagers in schools and religious organizations.

Appendix F. Suicide Intervention Form

This intervention form was developed by Susy Ruof, Joann Harris, and Mary Robbie, of the Weld County BOCES in La Salle, Colorado. Although lengthy, the form comprehensively covers the details of the intervention. It appears in the book *Handbook: Suicide Prevention in the Schools*, revised in 1987. Copies may be obtained by writing to Weld BOCES, P.O. Box 578, LaSalle, CO 80645-0578.

Appendix G. Suggested Readings and Materials

This appendix is not meant to be a comprehensive listing of suicide sources; rather, it represents readings and materials that may be useful in understanding the topic of suicide and intervention.

APPENDIX A

TEN SUICIDE SIGNS AND SIGNALS

1. Prevailing sadness, lack of energy, difficulty in concentrating, loss of interest or pleasure in usual activities, or atypical acting-out behaviors (i.e., anger, belligerence to authority figure, alcohol/drug abuse, sexual promiscuity, and running away from home).
2. Academic failure in school, often accompanied by the adolescent's feeling of disinterest or helplessness.
3. Social isolation, lack of close friends or confidants—even though the adolescent may have superficial contact with a group of peers.
4. Disharmony or disruption in the family (i.e., divorce, separation, alcoholism, and physical or sexual abuse).
5. Recent death or suicide attempt by a loved one or family member, or breakup with boyfriend or girlfriend.
6. Atypical eating or sleeping patterns—either excessive increase or decrease.
7. Verbal remarks about sense of failure, worthlessness, isolation, absence, or death; also written stories, essays, or art projects depicting the same themes.
8. Collecting pills, razor blades, knives, ropes, or firearms.
9. Giving away personal possessions and writing a suicide note.
10. Previous suicide attempts.

From *Teenage Suicide: What Can the Schools Do?* by Jerilyn K. Pfeiffer, p. 24. Copyright 1986 by the Phi Delta Kappa Educational Foundation. Reprinted with permission.

APPENDIX B

TEN MYTHS OF SUICIDE

- MYTH: People who talk about suicide rarely attempt or commit suicide.
- FACT: Approximately 70-75 percent of the people who attempt or commit suicide have given some verbal or nonverbal clue to their intentions.
- MYTH: The tendency toward suicide is inherited.
- FACT: Suicide has no characteristic genetic quality. Suicidal patterns in a family are a result of other factors and may result from a belief in the myth which facilitates suicidal actions.
- MYTH: The suicidal person wants to die.
- FACT: Suicidal persons often reveal considerable ambivalence about living vs. dying and frequently call for help before and after a suicide attempt.
- MYTH: Suicidal people are mentally ill.
- FACT: Many persons who have attempted or committed suicide would not have been diagnosed as mentally ill.
- MYTH: Once a person has attempted suicide, he/she will always be suicidal.
- FACT: After a suicide attempt, a person may be able to manage his/her life appropriately and engage in no further suicidal action.
- MYTH: Asking, "Are you thinking about committing suicide?" will lead the person to a suicide attempt.
- FACT: Asking a direct, caring question will often minimize the anxiety and act as a deterrent to suicidal behavior.
- MYTH: Suicide is more common in lower socioeconomic groups.
- FACT: Suicide crosses all socioeconomic group boundaries.
- MYTH: Suicidal persons rarely seek medical help.

Source: Ralph L. V. Rickman, *The Issue Is Suicide*. Copyright 1983 by the University of Minnesota. Reprinted with permission.

FACT: Studies of persons who have committed suicide indicate that 50 percent have sought medical help within six months of their action.

MYTH: Improvement in a suicidal person means the danger is over.

FACT: There is a significant danger within the first 90 days after a suicidal person is released from hospitalization.

MYTH: Only a mental health professional can prevent suicide.

FACT: Suicide prevention by lay persons and centers has been an important, significant part of suicide prevention activities.

APPENDIX C

STAFF TRAINING OUTLINE

TOPIC: Suicide Intervention in the School

TIME FRAME: Three- to four-hour in-service

AUDIENCE: All personnel in the school building including teachers, administrators, counselors, secretaries, custodians, campus supervisor, nurse, social worker, volunteers, etc.

OUTLINE:

- I. Introduction
 - A. Purpose of the in service
 - B. Expectations of the group
- II. Facts and Figures Relating to Suicide
 - A. National statistics
 - B. State figures
 - C. Local facts
- III. Suicide Myths and Misconceptions
- IV. Signals and Signs of Suicide
 - A. Detection of behaviors
 - B. High-risk students
 - C. Do's and Don'ts
- V. The Role of the School and Its Employees
 - A. "In loco parentis" role
 - B. Negligence
 - C. The need for confidentiality
- VI. Discussion of School Procedures
 - A. Prevention activities
 - B. Referral system
 - C. Dealing with attempts
 - D. "Postvention" (response to completion)
- VII. Closure
 - A. Question/answer period
 - B. Evaluation

APPENDIX D

CRISIS TEAM TRAINING OUTLINE

TOPIC: Crisis Intervention in the School

TIME FRAME: Eight- to ten-hour seminar

AUDIENCE: All crisis team members.

OUTLINE:

- I. Introduction
 - A. Purpose of the seminar
 - B. Expectations of the group
- II. Exploration of Death Attitudes
 - A. Personal experiences and feelings
 - B. Societal or local attitudes
 - C. Why suicide? Causes
- III. The High-Risk Child
 - A. Profile
 - B. Family characteristics
- IV. Legal Issues
 - A. "In loco parentis" doctrine
 - B. Negligence
 - C. Confidentiality
 - D. Referral
 - E. Obligation to the parents
 - F. Recordkeeping
- V. Assessment of Risk
 - A. Clues
 - B. Determining the level of risk
 - C. Assessment interviews
 - D. Intervention strategies
- VI. Crisis Intervention
 - A. General procedures
 - B. Dealing with survivors
 - C. Avoiding contagion
 - D. Management of the suicidal youth

- E. Team collaboration
- F. Parental resistance and denial
- VII. Networking
 - A. Working with communities
 - B. Agency involvement
 - C. Team maintenance
- VIII. Closure
 - A. Question/answer period
 - B. Evaluation

APPENDIX E

SAVE A FRIEND, SHARE A SECRET

Teen Years Can Be Tough

Teen years are not easy ones. Nobody needs to tell you that. Not only are you going through dramatic physical changes, your social world is also confusing.

Problems, demands, and pressure often seem to come from all directions. They seem to pull and tug at you. Sometimes, that makes coping with life difficult.

Fortunately, most teens have family and friends to help them through the bad times. They help find positive solutions to problems. They help sort things out.

But, sometimes teens are tempted to deal with problems by choosing to avoid them or by just numbing themselves to the pain. As a result they may act in self-destructive ways. Drug and alcohol abuse, eating disorders, and running away are examples of self-destructive behaviors. They don't really solve anything. They simply postpone reality.

Suicide Is No Option

Unfortunately, some teens may feel that the situation is so bad they even consider suicide as a solution. It's not! Suicide is a forever solution to a temporary situation. Suicide offers no tomorrows. It closes the door to the future. It's final.

You Can Help

If you have a friend who is experiencing difficult choices or facing unhappy times, you can help by just being a friend. Let him/her know that you care.

If at any time a friend mentions suicide, even in confidence, take it seriously. Be a friend. Urge your friend to seek help by talking to a school counselor, nurse, social worker, minister, psychologist, mental health worker, doctor, or by calling the Mental Health Crisis Line: 238-7871.

Produced jointly by the Suicide Prevention Task Force for Jeffco Youth and the Communications Committee of the Jefferson County Education Association (Colorado).

Then, *without delay* you need to discuss this with a school counselor or other trained adult so he/she can help prevent a tragedy. The loss of a single life, especially your friend's life, is a tragedy. But it's a tragedy that can be avoided if you just let the people who can help know in time.

Remember, it does no good to keep a secret if it means losing a friend.

"Every Kid Counts!"

APPENDIX F

SUICIDE INTERVENTION FORM WELD SCHOOL DISTRICT RE-5J (Confidential Information)

Referral date: _____

Student's Name: _____ D.O.B. _____ Age _____ Sex ☐ M ☐ F

School _____ Grade _____ Teacher _____

Parents' Names: _____ Address _____

_____ Phone (home) _____ (work) _____

Cite sources of information where possible. Use contact sheet for additional notes.

Recorded by: _____

Reason for referral

When incident occurred: _____ Who referred: _____

Content of referral incident:
(attach copy of note if applicable)

Self-destructive method/specifics of plan:

Is implement available? yes ____ no ____

Describe student's concept of death (finality, attractiveness):

Who does the student think would be most affected by his/her death?

Reprinted with permission from Ruof, Harris, and Robbie *Handbook. Suicide Prevention in the Schools*, Weld BOCES, Colorado, 1987.

Category of present self-destructive behavior (check any that apply):

- ☐ Serious attempt (doing something that he/she believes will cause death, having the conscious intent to die.)
- ☐ Mild attempt (a self-destructive act which the student perceives would not be a serious threat to life.)
- ☐ Suicidal threat (saying or doing something that indicates a self-destructive desire.)
- ☐ Suicidal ideation (having thoughts about killing oneself.)

History of suicidal behavior: ☐ self ☐ significant other;
who? _____

Prior threat(s) ☐ yes ☐ no (When? Describe.)

Prior attempt(s) ☐ yes ☐ no (When? How? Describe.)

History of counseling or mental health:

- Stresses: (check and circle any that apply)
- ☐ Loss of loved person by death, separation, divorce, alienation (who, when)
 - ☐ Loss of peer relationships, breakup with boyfriend/girlfriend
 - ☐ Absence of warm adult parental figure
 - ☐ Family factors (unemployment, frequent moves, frequent fights, abuse, etc.)
 - ☐ Loss of school/sports success, poor school performance
 - ☐ Much pressure to achieve
 - ☐ Loss of health through sickness, surgery or accident
 - ☐ Threat of prosecution, criminal involvement, or exposure
 - ☐ Other stresses:

- Symptoms:
- ☐ Disturbance in sleep/nightmares
 - ☐ Disturbance in appetite
 - ☐ Weight loss/gain
 - ☐ Social withdrawal/acting out/wide mood swings/temper tantrums
 - ☐ Evidence of masked rage or depression (fire setting, vandalism, encopresis, etc.)
 - ☐ Disturbance of overall activity level (hyper/slowed down)

- _____ Accident proneness
- _____ Truancy, running away
- _____ Poor impulse control
- _____ Physical complaints
- _____ Recent use of professional medical help (last three months)
- _____ Change in personal appearance
- _____ Preoccupation with death
- _____ Evidence of final arrangements (i.e., giving away prized possessions)
- _____ Increased trouble concentrating
- _____ Confused thinking
- _____ Seeing, hearing, feeling what is not there (hallucinations)
- _____ Extreme misinterpretations of events and others' behavior (delusions)

- Feelings:
- _____ Hopelessness/helplessness
 - _____ Feels should be punished
 - _____ Feels a lack of alternatives
 - _____ Feels a lack of support from significant others
 - _____ Anxiety
 - _____ Anger
 - _____ Sadness/depression
 - _____ Self-blame/guilt

Medical information (student/other family members):

- _____ Alcohol/drug misuse (Who? Describe pattern and quantity)
- _____ Student or family member is suffering from a chronic, debilitating illness (mental or physical) which has involved considerable change in self-image and self-concept. (Who? Describe.)
- _____ Change in general physical health (Who? Describe)

Resources (as seen by child).

Other possible resources

Lethality:

_____ High _____ Medium _____ Low

Action Plan

Crisis team members:

Date: _____

Plan of Action:

*Person
Responsible*

*Date
Done:*

Check actions taken:

Who

When

By Whom

_____ School administrator notified

_____ Parents notified

_____ Police notified

_____ Social Services notified

_____ Mental Health notified

_____ Others (specify)

WELD SCHOOL DISTRICT RE-5J
PARENT CONTACT SHEET (SUICIDE THREAT)

Child's Name _____ Date Contact _____

Interviewer(s) Name _____

Parent Contacted _____

Describe reaction of parent(s) to threat:

yes or no

_____ parent notified as to threat

_____ mental health recommended

_____ parent agreed to mental health

APPENDIX G

SUGGESTED READINGS AND MATERIALS

Books and Periodicals

Alvarez, A. *The Savage God: A Study of Suicide*. New York. Bantam Books, 1973.

Bernhardt, G. R., and Praeger, Susan G. "Preventing Child Suicide: The Elementary School Death Puppet Show." *Journal of Counseling and Development* 63 (January 1985): 311-12.

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Cain, A. C. *Survivors of Suicide*. Springfield, Ill.: Charles C. Thomas, 1972.

Davis, Patricia A. *Suicidal Adolescents*. Springfield, Ill.: Charles C. Thomas, 1983.

Elkind, David. *The Hurried Child: Growing Up Too Fast Too Soon*. Reading, Mass.: Addison-Wesley, 1981.

Faigel, H. D. "Suicide Among Young Persons. A Review for Its Incidence and Causes and Methods of its Prevention." *Clinical Pediatrics* (1966): 5, 187-90.

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Guetzloe, Eleanor C. *Youth Suicide. What the Educator Should Know*. Reston, Va.: Council for Exceptional Children, 1989. CEC/EPIC publication No. 331.

Pfeifer, J. K. *Teenage Suicide. What Can the Schools Do?* Bloomington, Ind.: Phi Delta Kappa Educational Foundation, 1986.

Wellman, Mary M. "The School Counselor's Role in the Communication of Suicidal Ideation by Adolescents." *School Counselor* 32 (November 1984). 104-9.

Manuals and Guides

A Teacher's Manual for the Prevention of Suicide Among Adolescents. The Samaritans, Inc., 33 Chestnut St., Providence, RI 02903.

Adolescent Suicide. Center on Evaluation, Development, Research, Phi Delta Kappa. Robert Cole, editor, Box 789, Bloomington, IN 47402.

Adolescent Suicide Awareness Program Manual. A Comprehensive Education and Prevention Program for School Communities. South Bergen Mental Health Center, Inc., 646B Valley Brook Ave., Lyndhurst, NJ 07071.

Adolescent Suicide Prevention Program: A Guide for Schools and Communities. Fairfax County Schools, Belle Willard Administration Center, 10310 Layton Hall Dr., Fairfax, VA 22030

Handbook: Suicide Prevention in the Schools. Susy Ruof, Joann Harris, and Mary Robbie, 1987. WELD BOCES, P.O. Box 578, LaSalle, CO 80645.

The Self Destructive Behavior of Adolescents. Seeking Solutions (Student Curriculum). Cherry Creek Public Schools, 3301 So. Monaco Blvd., Denver, CO 80222.

Youth in Crisis: Seeking Solutions to Self-Destructive Behavior. Tom Barrett, 1985. Sopris West, Inc., 1120 Delaware Ave., Longmont, CO 80501

Videos

Cline, Foster. *Straight Talk About Suicide.* Cline/Fay Institute, Inc., P.O. Box 2362, Evergreen, CO 80439.

Craig, James. *The Ultimate Rejection.* Media Center, Wright State University, Dayton, OH 45435.

Teenage Suicide (15 minutes). MTI Teleprograms, Inc.

Suicide, But Jack Was a Good Driver (14 minutes). McGraw-Hill Films, CRM Films Collection, Finksburg, MD. National Educational Film Center.

Suicide: Who Will Cry for Me? Pleasantville, N.Y.: Audio-Visual Narrative Arts, 1979.

For Additional Film and Media Resources on Youth Suicide Contact:

Youth Suicide National Center
1825 Eye Street, N.W., Suite 400
Washington, DC 20006
(202) 429-2016

and

M.L.A. Productions, Inc.
150 South Grant Street
Wilkes-Barre, PA 18702
(717) 825-7031

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13. "26 Child-Abuse Deaths in '88 Nearly Double State's '87 Toll," *Denver Post*, March 31, 1989, p. 1.
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15. "Our Troubled Teens," p. 37.
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23. "Our Troubled Teens," p. 23.
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 25. *Adolescent Health in Colorado*, p. 11
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2. **The Role of the Schools**, pp. 12-16.
 1. Rickgarn, Ralph L. V., *The Issue Is Suicide* (Minneapolis: University of Minnesota, 1983).
 2. Barrett, Thomas C., *Youth in Crisis. Seeking Solutions to Self Destructive Behavior* (Longmont, Colo.: Sopris West, 1985), p. 12.
 3. "Parents Blame School in Lawsuit for Not Preventing Son's Death," *Denver Post*, March 16, 1987.
 3. **Becoming Response-Ready: The Crisis Team Approach**, pp. 17-19.
 1. McCarthy, Martha, and Cambron, Nelda, *Public School Law. Teachers' and Students' Rights* (Boston: Allyn and Bacon, 1981), pp. 207, 208.
 4. **The Contingency Plan**, pp. 20-26.
 1. "Youth Suicide Prevention Targeted," *Rocky Mountain News*, April 10, 1989, p. 7.
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 3. "Suicide Epidemic," *Rocky Mountain News*, July 8, 1988, p. 3.
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